FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0022947

Facility Name: Pershing Estates

Address: 1016 W. Pershing Rd. (Number) Decatur (City) 62526 (Zip Code)

County: Macon

Telephone Number: 217-875-0833 **Fax #** 217-875-6851

IDPA ID Number: 370969602002

Date of Initial License for Current Owners: 12-01-76

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Denise King **Telephone Number:** 217-429-2500

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1-1-2002 to 12-31-2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ 3-27-03 (Date)
(Type or Print Name) Denise King
(Title) Corporate Secretary

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Pershing Estates # 0022947 Report Period Beginning: 1-1-2002 Ending: 12-31-2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	137	Intermediate (ICF)	137	50,005	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	137	TOTALS	137	50,005	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	35,152	2,049	1,337	38,538	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	35,152	2,049	1,337	38,538	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.07%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/01/76

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Pershing Estates # 0022947 **Report Period Beginning:** 1-1-2002 **Ending:** 12-31-2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	127,637	2,031	8,720	138,388		138,388		138,388			1
2	Food Purchase		160,980		160,980	(180)	160,800	(33)	160,767			2
3	Housekeeping	86,566			86,566		86,566		86,566			3
4	Laundry											4
5	Heat and Other Utilities			77,524	77,524		77,524		77,524			5
6	Maintenance	38,176	21,012	57,923	117,111		117,111		117,111			6
7	Other (specify):* Resident workers	28,053			28,053		28,053		28,053			7
8	**TOTAL General Services**	280,432	184,023	144,167	608,622	(180)	608,442	(33)	608,409			8
	B. Health Care and Programs											
9	Medical Director			30,950	30,950		30,950		30,950			9
10	Nursing and Medical Records	572,496	24,527	1,800	598,823		598,823		598,823			10
10a	Therapy											10a
11	Activities	49,437	1,656	1,440	52,533		52,533		52,533			11
12	Social Services	69,107		1,440	70,547		70,547		70,547			12
13	Nurse Aide Training											13
14	Program Transportation			4,455	4,455		4,455		4,455			14
15	Other (specify):* QMRP	82,375			82,375		82,375		82,375			15
16	**TOTAL Health Care and Programs**	773,415	26,183	40,085	839,683		839,683		839,683			16
	C. General Administration											
17	Administrative	320,220			320,220		320,220		320,220			17
18	Directors Fees											18
19	Professional Services			3,511	3,511		3,511		3,511			19
20	Dues, Fees, Subscriptions & Promotions			9,968	9,968		9,968	(125)	9,843			20
21	Clerical & General Office Expenses	78,648	9,158	18,649	106,455		106,455	(5,898)	100,557			21
22	Employee Benefits & Payroll Taxes			180,577	180,577	180	180,757		180,757			22
23	Inservice Training & Education			885	885		885		885			23
24	Travel and Seminar			600	600		600		600			24
25	Other Admin. Staff Transportation			5,905	5,905		5,905	(4,683)	1,222			25
26	Insurance-Prop.Liab.Malpractice			63,761	63,761		63,761		63,761			26
27	Other (specify):*											27
28	**TOTAL General Administration**	398,868	9,158	283,856	691,882	180	692,062	(10,706)	681,356			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,452,715	219,364	468,108	2,140,187		2,140,187	(10,739)	2,129,448			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Pershing Estates #0022947 Report Period Beginning: 1-1-2002 Ending: 12-31-2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			55,780	55,780		55,780	(18,773)	37,007			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			44,040	44,040		44,040		44,040			32
33	Real Estate Taxes			57,440	57,440		57,440		57,440			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			157,260	157,260		157,260	(18,773)	138,487			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops	4,794	67		4,861		4,861		4,861			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			75,007	75,007		75,007		75,007			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	4,794	67	75,007	79,868		79,868		79,868			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,457,509	219,431	700,375	2,377,315		2,377,315	(29,512)	2,347,803			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Pershing Estates # 0022947 Report Period Beginning: 1-1-2002 Ending: 12-31-2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(11,664)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(33)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(3,376)	21		15
16	Personal Expenses (Including Transportation)	(4,683)	25		16
17	Non-Care Related Fees	(7,109)	30		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(125)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(2,522)	21		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (29,512)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (29,512)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Pershing Estates

ID# 0022947

Report Period Beginning: 1-1-2002

Ending: 12-31-2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Pershing Estates # 0022947 **Report Period Beginning:** 1-1-2002 **Ending:** 12-31-2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(33)	0	0	0	0	0	0	0	0	0	0	(33)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(33)	0	0	0	0	0	0	0	0	0	0	(33)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(125)	0	0	0	0	0	0	0	0	0	0	(125)	20
21	Clerical & General Office Expenses	(5,898)	0	0	0	0	0	0	0	0	0	0	(5,898)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(4,683)	0	0	0	0	0	0	0	0	0	0	(4,683)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(10,706)	0	0	0	0	0	0	0	0	0	0	(10,706)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(10,739)	0	0	0	0	0	0	0	0	0	0	(10,739)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Pershing Estates** **#** **0022947** **Report Period Beginning:** **1-1-2002** **Ending:** **12-31-2002**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(18,773)	0	0	0	0	0	0	0	0	0	0	(18,773)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(18,773)	0	0	0	0	0	0	0	0	0	0	(18,773)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(29,512)	0	0	0	0	0	0	0	0	0	0	(29,512)	45

Facility Name & ID Number Pershing Estates # 0022947 Report Period Beginning: 1-1-2002 Ending: 12-31-2002

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Contemporary Properties, Inc./N.Striglos	100	None				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Pershing Estates # 0022947 Report Period Beginning: 1-1-2002 Ending: 12-31-2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Nick Striglos	President	Management	100.00	None	18	45.00	Salary	$ 215,560	17-1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 215,560		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Pershing Estates # 0022947 Report Period Beginning: 1-1-2002 Ending: 2-31-2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Pershing Estates # 0022947 Report Period Beginning: 1-1-2002 Ending: 12-31-2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Nick Striglos	X		Facility addition	$12,200.00	1/7/98	$ 275,000	$ 29,529	1/2003	14.0000	$ 16,878	1
2						&6/1/98	250,000					2
3												3
4												4
5												5
	Working Capital											
6	Stifel Nicolaus/N.Striglos	X		Cash flow due to late IDPA	(Open)	12/28/01	300,000	150,000	Open	5.0000	27,162	6
7				payments								7
8	Stifel Nicolaus/N.Striglos	X		Same as above	(Open)	11/18/02	65,000	65,000	Open	5.0000		8
9	TOTAL Facility Related				$12,200.00		$ 890,000	$ 244,529			$ 44,040	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 890,000	$ 244,529			$ 44,040	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line #

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Pershing Estates # 0022947 Report Period Beginning: 1-1-2002 Ending: 12-31-2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	50,972	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	54,206	2
3. Under or (over) accrual (line 2 minus line 1).	$	3,234	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	54,206	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	57,440	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	36,426	8
	1998	46,761	9
	1999	47,137	10
	2000	50,972	11
	2001	54,206	12

Accrual based on amount paid in 2002 for 2001.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Pershing Estates COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0022947

CONTACT PERSON REGARDING THIS REPORT Denise King

TELEPHONE 217-429-2500 FAX #: 217-429-0081

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	07-07-34-351-013	N450.63' S950.63' W405.2' E652.2'	$ 53,978.82	$ 53,978.82
2.		SW1/4 SW1/4 EZ	$	$
3.	07-30-00-000-077	Enterprise Zone PCL 2 of 2	$ 226.84	$ 226.84
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 54,205.66	$ 54,205.66

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Pershing Estates # 0022947 Report Period Beginning: 1-1-2002 Ending: 12-31-2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,860 B. General Construction Type: Exterior Masonry Frame Metal Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility/yard	130,680	1976	$ 38,000	1
2					2
3	TOTALS	130,680		$ 38,000	3

Facility Name & ID Number Pershing Estates # 0022947 Report Period Beginning: 1-1-2002 Ending: 12-31-2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	127		1976	1973	$ 423,394	$	25	$	$	$ 423,394	4
5	10		1998	1998	470,332	11,458	25	18,813	7,355	75,252	5
6	Fixed equip.		1976	1976	70,012		VAR			70,012	6
7											7
8											8
	Improvement Type**										
9	Remodeling 1978			8/1/1978	16,657		VAR			16,657	9
10	Remodeling 1979			12/1/1979	8,066		VAR			8,066	10
11	47 cases floor tile			9/1/1982	1,410		7			1,410	11
12	Carpet & tile			9/1/1983	2,096		10			2,096	12
13	Floor tile			12/1/1984	312		7			312	13
14	1985 Improvements			6/1/1985	8,321	433	13		(433)	8,321	14
15	Floor & ceiling tile			6/10/1905	1,552		5			1,552	15
16	Water heater			1989	843		12	33	33	843	16
17	Flooring			1989	2,288		5			2,288	17
18	Storage shed			1989	454		20	23	23	326	18
19	Flooring			1989	2,919		5			2,919	19
20	Sliding glass door replacement			5/23/1989	830	26	11		(26)	830	20
21	Fire wall			11/17/1989	1,475	47	11		(47)	1,475	21
22	Laundry room service			12/14/1989	900		11			900	22
23	Wallpaper, carpet & floor tile			6/12/1990	2,749		5			2,749	23
24	Curtains, water heater, smoke eater, A/C			1990	19,559	246	10		(246)	19,559	24
25	Floor tile & A/C's			1991	5,147		7			5,147	25
26	Water heater, valves & pump			10/22/1991	4,974	158	15	332	174	3,706	26
27	Floor tile, carpet, A/C			1992	2,953		7			2,953	27
28	New roof--one wing			10/26/1992	5,500	175	9		(175)	5,500	28
29	Carpet & tile			1/29/1993	1,657		7			1,657	29
30	A/C & fire suppression system			8/24/1993	3,830		10	383	383	3,589	30
31	A/C & tile			1994	3,849		7			3,849	31
32	Quarry tile & patio door			1994	3,850	21	10	385	364	3,208	32
33	Carpet, tile, roof (one wing), A/C			1995	8,676	101	7	773	672	8,676	33
34	Water heaters			1995	6,029		15	402	402	3,137	34
35	A/C			6/28/1996	975		7	139	139	904	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Pershing Estates # 0022947 Report Period Beginning: 1-1-2002 Ending: 12-31-2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Carpeting 108 yds.	9/20/1996	$ 1,603	$	7	$ 229	$ 229	$ 1,431	37
38	Floor tile & base	1997	982		7	140	140	805	38
39	New roof--one wing	1997	4,245	109	15	283	174	1,486	39
40	Partial roof replacement	1997	875	22	10	88	66	447	40
41	Carpeting	1997	1,142		7	163	163	883	41
42	Phone lines	1998	1,462	130	15	97	(33)	453	42
43	Light fixtures for sidewalk	1998	2,875	257	15	192	(65)	800	43
44	Phones lines, expand Muzak	1998	690	62	10	69	7	362	44
45	Furnaces	1998	2,475	221	7	354	133	1,711	45
46	A/C	1998	1,350	120	7	193	73	852	46
47	Backflow prevention device, materials adjustment	1998	4,976	444	15	332	(112)	1,439	47
48	Roof top furnace	1998	3,000	268	10	300	32	1,200	48
49	Balance of new addition	1999	25,316	633	25	1,013	380	3,376	49
50	Smoking room	1999	5,534	139	15	369	230	922	50
51	Handrails for smoking room	1999	853		15	57	57	228	51
52	A/C--furnace unit	2000	2,900		7	414	414	1,242	52
53	A/C unit & compressor	2000	4,000		7	571	571	1,428	53
54	Carpeting & vinyl	2000	1,593		7	228	228	551	54
55	TICA furnace & coil	2000	1,581		7	226	226	490	55
56	A/C--furnace unit	2000	2,900		7	414	414	863	56
57	New roof	2000	14,325	367	25	573	206	1,528	57
58	Handicapped access ramp	2001	11,018	280	25	441	161	478	58
59	A/C unit	2001	1,150		7	164	164	274	59
60	Tempstar furnace	2002	1,500	713	7	214	(499)	214	60
61	Goodman A/C 3.5 ton	2002	1,200	510	7	86	(424)	86	61
62	Goodman A/C 3.5 ton	2002	1,200	450	7	86	(364)	86	62
63	Simplex nurse call system	2002	24,800	24,600	15	276	(24,324)	276	63
64	Tempstar furnace w/coil	2002	1,469	477	7	17	(460)	17	64
65	Tempstar furnace w/coil	2002	1,454	473	7	17	(456)	17	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,210,077	$ 42,940		$ 28,889	$ (14,051)	$ 705,232	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Pershing Estates # 0022947 Report Period Beginning: 1-1-2002 Ending: 12-31-2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 41,967	$ 1,974	$ 5,978	$ 4,004	Var	$ 25,522	71
72	Current Year Purchases	1,192	447	71	(376)	Var	71	72
73	Fully Depreciated Assets	169,507				Var	169,507	73
74								74
75	TOTALS	$ 212,666	$ 2,421	$ 6,049	$ 3,628		$ 195,100	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident transportation	1999 Chevy Express van	2001	$ 10,343	$ 3,310	$ 2,069	$ (1,241)	5	$ 2,414	76
77										77
78										78
79										79
80	TOTALS			$ 10,343	$ 3,310	$ 2,069	$ (1,241)		$ 2,414	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,471,086	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 48,671	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 37,007	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (11,664)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 902,746	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	1991 Mercedes	$ 60,182	$ 1,575	$ 21,971	86
87	1995 BMW	36,391	1,775	16,531	87
88	1999 Mercedes	53,853	1,775	23,092	88
89					89
90					90
91	TOTALS	$ 150,426	$ 5,125	$ 61,594	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Pershing Estates # 0022947 Report Period Beginning: 1-1-2002 Ending: 12-31-2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   Nurse aides hired are already certified.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Pershing Estates # 0022947 **Report Period Beginning:** 1-1-2002 **Ending:** 12-31-2002

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12-31-2002 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 48,794	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	464,750		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Employee loans	1,899		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 515,443	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	280,853		11
12	Long-Term Investments			12
13	Land	38,000		13
14	Buildings, at Historical Cost	1,002,214		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	494,660		16
17	Accumulated Depreciation (book methods)	(946,994)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Reconcile cash/accrual	(431,532)		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 437,201	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 952,644	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 33,218	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	215,000		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 248,218	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	29,529		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 29,529	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 277,747	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 674,897	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 952,644	$	48

***(See instructions.)**

Facility Name & ID Number Pershing Estates # 0022947 Report Period Beginning: 1-1-2002 Ending: 12-31-2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 791,532	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 791,532	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	272,008	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(593,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (320,992)	17
	B. Transfers (Itemize):		
18	**Reconcile cash/accrual**	204,357	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 204,357	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 674,897	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Pershing Estates # 0022947 Report Period Beginning: 1-1-2002 Ending: 12-31-2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,845,331	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,845,331	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	964	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 964	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,846,295	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	608,622	31
32	Health Care	839,683	32
33	General Administration	691,882	33
	B. Capital Expense		
34	Ownership	157,260	34
	C. Ancillary Expense		
35	Special Cost Centers	4,861	35
36	Provider Participation Fee	75,007	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,377,315	40
41	**Income before Income Taxes (line 30 minus line 40)****	468,980	41
42	**Income Taxes**	(196,972)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 272,008	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.** **Tax return is on cash basis.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Pershing Estates # 0022947 Report Period Beginning: 1-1-2002 Ending: 12-31-2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,194	2,378	$ 46,854	$ 19.70	1
2	Assistant Director of Nursing	2,409	2,537	46,944	18.50	2
3	Registered Nurses	3,996	4,151	70,107	16.89	3
4	Licensed Practical Nurses	10,940	11,283	159,312	14.12	4
5	Nurse Aides & Orderlies	33,457	34,529	249,279	7.22	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,016	2,097	20,271	9.67	9
10	Activity Assistants	4,733	4,958	29,166	5.88	10
11	Social Service Workers	6,135	6,419	69,107	10.77	11
12	Dietician					12
13	Food Service Supervisor	1,975	2,095	29,097	13.89	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,733	17,125	98,540	5.75	15
16	Dishwashers					16
17	Maintenance Workers	3,863	4,154	38,176	9.19	17
18	Housekeepers	12,254	12,829	86,566	6.75	18
19	Laundry					19
20	Administrator	2,000	2,136	62,119	29.08	20
21	Assistant Administrator	1,944	2,080	42,541	20.45	21
22	Other Administrative	936	936	215,560	230.30	22
23	Office Manager	1,944	2,080	31,397	15.09	23
24	Clerical	4,017	4,257	47,251	11.10	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	10,030	10,712	82,375	7.69	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Beautician	803	820	4,794	5.85	32
33	Other(specify) Resident workers	10,009	10,009	28,053	2.80	33
34	TOTAL (lines 1 - 33)	132,388	137,585	$ 1,457,509 *	$ 10.59	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	192	$ 8,720	1-3	35
36	Medical Director	Flat fee	30,950	9-3	36
37	Medical Records Consultant	Flat fee	1,800	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	1,440	11-3	44
45	Social Service Consultant	48	1,440	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	288	$ 44,350		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Pershing Estates # 0022947 Report Period Beginning: 1-1-2002 Ending: 12-31-2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Nick Striglos	Management	100	$ 215,560
Sheila Herndon	Administrator	0	62,119
Denise King	Management	0	42,541
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 320,220

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
May, Cocagne & King	Accounting	$ 860
Winston & Strawn	Legal	2,651
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 3,511

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 22,355
Unemployment Compensation Insurance	12,985
FICA Taxes	103,149
Employee Health Insurance	30,522
Employee Meals	643
Illinois Municipal Retirement Fund (IMRF)*	
Christmas	1,110
TB tests	470
Pension	9,523
TOTAL (agree to Schedule V, line 22, col.8)	$ 180,757

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	655
Health Care Worker Background Check	948
(Indicate # of checks performed 79)	
Nursing home association dues	7,022
Annual corporate fees	768
HCFA Lab Program	150
Macon Cty. Health Dept.--food license	300
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,843

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	600
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 600

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Pershing Estates # 0022947 Report Period Beginning: 1-1-2002 Ending: 12-31-2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Pershing Estates # 0022947 **Report Period Beginning:** 1-1-2002 **Ending:** 12-31-2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Ill. Council on Long Term Care $7022

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 0 Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 75,007
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 180 Has any meal income been offset against related costs? Yes Indicate the amount. $ 1,997

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. $ 0

(17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

Pension:		Pershing Estates
Owner	1714	#0022947
All others	7809	1/1/2002-12/31/2002
Total	9523	

Total employees=48